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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Transforaminal ESI at L3-L4 on the left

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his lower back on XX/XX/XX, when xxxxxxxxxx.

On xxxxxxx, the request for a lumbar epidural steroid injection (ESI) was denied with the following rationale: *"Based on the clinical information provided, the request for lumbar epidural steroid injection is not recommended as medically necessary. The request is nonspecific and does not indicate the level/laterality to be injected. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic*

results. The submitted lumbar magnetic resonance imaging (MRI) fails to document any significant neurocompressive pathology. Therefore, medical necessity is not established in accordance with current evidence based guidelines. This review results in the following determination regarding the treatment being requested: Adverse Determination." The following records are documented within the determination: The patient was treated initially at where he was diagnosed with back pain and a lumbar sprain. He was referred for a lumbar MRI, which was completed on xxxxx and revealed multiple disc bulges and stenosis.

On xxxxxx, the appeal for left L3-L4 transforaminal ESI was denied with the following rationale: *"This is an appeal of a previously denied request. The previous review denied the request due to a non-specific request, which did not indicate the level and laterality to be injected. This has been addressed. The request is for left L3-4 transforaminal ESI. The patient has chronic low back pain rated 7/10 in severity. The most recent clinical findings showed mild weakness (4cI5) on left plantarflexion. These findings are not concordant with pathology at L3-4 and the level to be injected. There was no sensory lose in this dermatome and knee extension was not described as weak. The 08/05/15 progress note described weakness over the left gastroc-soleus, which is also not consistent with L3-4 nerve root impingement. Imaging revealed most significant changes at L3-4 with a central disc protrusion at L3-4 and mild neural foramina1 stenosis at several levels, without significant nerve root encroachment at any level. ODG does not support epidural injections in the absence of objective radiculopathy. In addition, ODG criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology; and conservative treatment. Electrodiagnostic testing may be helpful in objectively correlating presence of radiculopathy at the L3-4 level and substantiating the need for ESI. However, as there was no clinical evidence of radiculopathy consistent with the level requested, medical necessity was not established. Recommend non-certification."*

Additional records were reviewed as follows: The magnetic resonance imaging (MRI) of the lumbar spine dated xxxxx revealed very mild disc degeneration in the lumbar spine. There is a central disc protrusion at L3-4 measuring about 5 mm. There are minimal disc bulges at the other levels. There is no evidence of significant arthrosis. There is mild neural foraminal stenosis at a few levels. There is no significant traversing nerve root encroachment at any level. xxxxx Progress note reported low back pain with left leg numbness. Physical examination showed absent patellar reflex and decreased Achilles tendon reflex (+I) bilaterally. Sensory examination was intact bilaterally. Note dated xxxx indicates that the patient has had one session of physical therapy thus far. Note dated xxx indicates that he has completed 6 sessions of physical therapy with no relief. Office visit note dated xxxxx indicates that strength is 5/5 with the exception of left plantar flexion. The sensation is intact bilaterally. Straight leg raising is negative on the right and positive on the left."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

There is an L34 radiculopathy with neurological loss/findings clearly caused by the HNP. An epidural injection is appropriate and medically necessary, and consistent with ODG.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- **x ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**